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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16752

CERTIFICATE OF DEATH

16747

1. PLACE OF DEATH a. COUNTY CAROLINE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CAROLINE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RODGELY		c. LENGTH OF STAY IN 1b LIFE	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RODGELY		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle DENNIS Last BINEBRINK		4. DATE OF DEATH Month DEC Day 6 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR 17, 1889
9. AGE (In years and birthday) 78 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES MAN	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES MAN		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM J. BINEBRINK		14. MOTHER'S MAIDEN NAME NORA LANE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT Address MRS. W.M. BINEBRINK, RODGELY		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anterior Ischemic Heart Disease 4200 DUE TO decompensated Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 6/30/67 , 19 67 , to 11/20 , 19 67 , that (I) (we) last saw the deceased alive on 11/20/67 , and that death occurred at 10:00 M, from causes and on the date stated above.	
22a. SIGNATURE Phly. Dwyer		22b. DATE SIGNED 12/8/67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF DEC 9, 1967	
23c. NAME OF CEMETERY OR CREMATORY GREENMOUNT		23d. LOCATION (City or Town) (County) (State) HILLSBORO MD.	
24. FUNERAL DIRECTOR ADDRESS D. VERGEL MOORE DENTON MD.		25a. REC'D BY REGISTRAR DEC 12 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

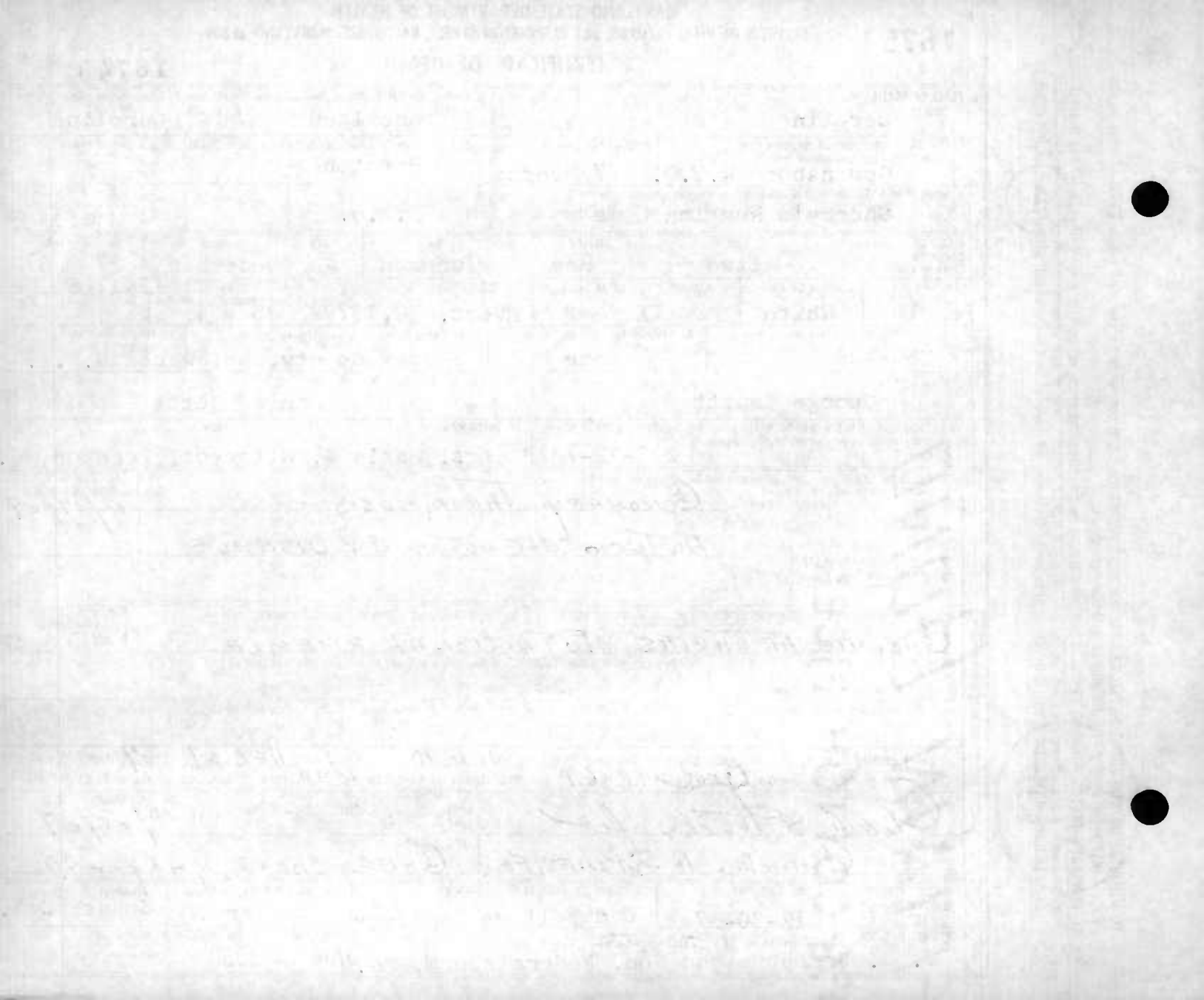
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Caroline MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greensboro R.F.D.				c. LENGTH OF STAY IN lb 7 Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cherry's Nursing Home						d. STREET ADDRESS R.F.D.				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alice Middle Mae Last Johnson						4. DATE OF DEATH Month December Day 27 Year 1967					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 20, 1879		9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Sussex County, Delaware				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Truitt						14. MOTHER'S MAIDEN NAME Annie Betts					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 213-22-7323		17. INFORMANT Address Mrs. Marie S. Hilprect, Preston, Md.					
18. CAUSE OF DEATH (Enter only one cause per line in (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) CORONARY THROMBOSIS DUE TO (b) ARTERIOSCLEROTIC C.V. DISEASE DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. INTERVAL BETWEEN ONSET AND DEATH 12/27/67											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CHRONIC ARTHRITIS; NUTRITIONAL ANEMIA											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from JAN 10, 1967 , to DEC 27, 1967 , that (I) (we) last saw the deceased alive on OCT 27, 1967 , and that death occurred at 10 AM , from causes and on the date stated above.											
22a. SIGNATURE <i>Charles H. Stinesifer</i>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/28/67			
22c. PHYSICIAN'S NAME (Type) CHARLES H. STINESIFER						22d. ADDRESS GREENSBORO, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-30-67		23c. NAME OF CEMETERY OR CREMATORY Odd Fellows Cemetery		23d. LOCATION (City or Town) (County) (State) Seaford, Sussex Del.					
24. FUNERAL DIRECTOR Margaret H. Frampton J. J. Frampton and Son, Federalburg, Md.						25a. REC'D BY REGISTRAR JAN 2 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

MEDICAL CERTIFICATION



16754

CERTIFICATE OF DEATH

16749

1. PLACE OF DEATH a. COUNTY <u>CAROLINE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RI DGE LY</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>RI DGE LY</u> 05.1			
3. NAME OF DECEASED (Type or print) First <u>ANNIE</u> Middle <u>TODD</u> Last <u>SAMES</u>				4. DATE OF DEATH Month <u>DEC</u> Day <u>23</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 26, 1875</u>		9. AGE (In years last birthday) yrs. <u>92</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13. FATHER'S NAME <u>JAMES MASON</u>				14. MOTHER'S MAIDEN NAME <u>MATILDA JOHNSON</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MRS. PAGE JONES, RIDGE LY MD.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Virulent Viral Enterocolitis</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic C.V. Disease, Disabling old fracture of the hip</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 16</u> , 19 <u>67</u> , to <u>Dec 23</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Dec. 23</u> , 19 <u>67</u> , and that death occurred at <u> </u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Charles H. Stonesifer</u>				22b. DATE SIGNED <u>12/26/67</u>		22c. PHYSICIAN'S NAME (Type) <u>Charles H. Stonesifer, M.D.</u>	
22d. ADDRESS <u>Greensboro, Md.</u>				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Dec. 26, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>RI DGE LY</u>		23d. LOCATION (City or Town) (County) (State) <u>RI DGE LY CAR. MD.</u>	
24. FUNERAL DIRECTOR <u>CHARLES V. MOORE JENKINS RD.</u>				25a. REC'D BY REGISTRAR <u>DEC 29 1967</u>		25b. REGISTRAR'S SIGNATURE <u>James Judge</u>	

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EASTON

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Henderson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Henderson	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) None		d. STREET ADDRESS None	
3. NAME OF DECEASED (Type or print) Ida First Middle Last		4. DATE OF DEATH 12-26-67 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-8-1873
9. AGE (In years last birthday) 94 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HouseKeeper		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Schuyler		14. MOTHER'S MAIDEN NAME Matelda Hughes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Edward Schuyler Henderson, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4221 IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO (b) Generalized Arteriosclerosis DUE TO (c) Malnutrition and Nutritional Anemia			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 1, 1967 , to Dec. 26, 1967 that (I) (we) last saw the deceased alive on Dec. 26, 1967 , and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE Charles H. Stonecipher, M.D.		22b. DATE SIGNED Dec. 28 '67	
22c. PHYSICIAN'S NAME (Type) Charles H. Stonecipher, M.D.		22d. ADDRESS Greensboro, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-29-67	23c. NAME OF CEMETERY OR CREMATORY Greensboro	23d. LOCATION (City or Town) (County) (State) Greensboro, Maryland
24. FUNERAL DIRECTOR J. E. Boulaie, Greensboro, Md.		25a. REC'D BY REGISTRAR J. Charles Judge	
25b. REGISTRAR'S SIGNATURE J. Charles Judge		DATE JAN 4 1968	

MEMORANDUM FOR THE RECORD

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**MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

FOR STATE HEALTH DEPT.

16756

16751

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Preston, Md. RFD.</u> c. LENGTH OF STAY IN 1b <u>37 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>rural</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Caroline</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural</u> d. STREET ADDRESS <u>none</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Thomas M.</u> Middle <u>Wood</u> Last <u></u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>10</u> Year <u>1967</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>Oct. 12, 1917</u>		9. AGE (In years last birthday) <u>50 yrs.</u>		10. IF UNDER 1 YEAR Months <u></u> Days <u></u>			
11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>bldg. supply co.</u>			
11. BIRTHPLACE (State or foreign country) <u>Boston, Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Albert T. Wood</u>			
14. MOTHER'S MAIDEN NAME <u>Cora Fuller</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>			
17. INFORMANT <u>Mrs. Mary Jane Wood</u>		18. ADDRESS <u>Preston, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vacular Accident Probaly Hemorrhage minutes</u> DUE TO <u>Hypertensive arteriosclerotic Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Reheal 75yrs</u> DUE TO <u>Generalized arteriosclerosis severe for age 15 yrs</u> (c) <u>?</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?full mental capacity mental age of about 12yrs</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>					
20c. TIME OF INJURY Hour <u></u> a. m. <u></u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>			
20f. (City or town) <u></u>		(County) <u></u>		(State) <u></u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Harold B. Plummer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Caroline Maryland</u>		DATE SIGNED <u>12/12/67</u>			
EXAMINER'S NAME (Type) <u>Harold B. Plummer</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>					
22b. DATE THEREOF <u>12/13/67</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bloomery Cem.</u>		22d. LOCATION (City, town, or county) <u>Federalsburg, Md. RFD.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey W. Robinson</u>		ADDRESS <u>Federalsburg, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 15 1967</u>			
24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		24c. REGISTRAR'S SIGNATURE <u></u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1675

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for patient information, medical history, and examination findings. The form is partially obscured by a large, light-colored, irregular shape on the left side.

1. PATIENT INFORMATION

2. MEDICAL HISTORY

3. EXAMINATION FINDINGS

4. CAUSE OF DEATH

5. SIGNATURES

6. NOTES

Vertical text on the right margin, likely a date stamp or filing information.